John Deere Health Plan, Inc.

For the Period
January 1, 1998, Through December 31, 1999

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STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY
State Capitol
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John G. Morgan
Comptroller

September 28, 2001

The Honorable Don Sundquist, Governor
and
Members of the General Assembly
State Capitol
Nashville, Tennessee 37243
and
Mr. Mark Reynolds, Director
Bureau of TennCare
729 Church Street, Fifth Floor
Nashville, Tennessee 37247

Ladies and Gentlemen:

Pursuant to the agreement between the Comptroller of the Treasury and the Department of Health, the Division of State Audit performs examinations of managed care organizations participating in the Tennessee TennCare Program under Title XIX of the Social Security Act.

Submitted herewith is the report of the examination of John Deere Health Plan, Inc., for the period January 1, 1998, through December 31, 1999.

Sincerely,

John G. Morgan
Comptroller of the Treasury

JGM/pn
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State of Tennessee

Audit Highlights

Comptroller of the Treasury | Division of State Audit

TennCare Report
John Deere Health Plan, Inc.
For the Period January 1, 1998, Through December 31, 1999

Findings

Deficiencies in Claims Processing System
John Deere Health Plan, Inc. (JDHP), did not fulfill contract reporting requirements and processing efficiency requirements specified by the TennCare contract. Claims were improperly denied or incorrectly paid. Errors were discovered in the explanation of benefits sent to TennCare members (page 6).

Deficiencies in Encounter Data Reporting
Inadequate encounter data were reported to TennCare (page 8).

Provider Contract Language Deficiencies
JDHP did not include in the provider agreements all requirements specified by the TennCare contract (page 9).

"Audit Highlights" is a summary of the audit report. To obtain the complete audit report, which contains all findings, recommendations, and management comments, please contact

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TennCare Report
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INTRODUCTION

PURPOSE AND AUTHORITY OF THE EXAMINATION

The terms and conditions for authorizing the TennCare Program, as well as the contracts between the State of Tennessee and the managed care organizations (MCOs), require that examinations of the managed care organizations be conducted by the Tennessee Comptroller's Office. The contract between the Tennessee Department of Health and the Comptroller's Office also contains a provision requiring the examinations.

Under their contract with the state, the MCOs have asserted that they are in compliance with stated requirements regarding their provision of services to TennCare enrollees. The purpose of our examination is to render an opinion on the MCOs' assertions that they have complied with certain financial-related requirements of their contract with the state.

BACKGROUND

The Tennessee Department of Health is the single state agency responsible for administering the TennCare Program and the TennCare Partners Program. On January 1, 1994, the TennCare Program began as an approved federal waiver replacing the then existing Medicaid Program. TennCare encompasses all services other than mental health and long-term care. On July 1, 1996, the TennCare Partners Program was initiated. TennCare Partners, which functions in the same manner as the regular TennCare Program, covers mental health services. Long-term care continues to be excluded from all TennCare waivers. The state contracts with private health maintenance organizations to provide TennCare services to beneficiaries. The health maintenance organizations are referred to as managed care organizations (MCOs).

Recipients who meet Medicaid eligibility standards are enrolled in the TennCare Program and TennCare Partners Program. In addition, certain uninsured and uninsurable individuals are eligible for enrollment. Uninsured persons may be required to pay a monthly premium. The contracting MCOs provide care for TennCare enrollees for a stated monthly capitation fee. The MCOs in turn arrange for a network of hospitals, doctors, and other health care providers to furnish health care services for persons enrolled in the plan. Essentially, the program functions much the same as a conventional health care delivery system under managed care.

Effective January 1, 1994, Heritage National Healthplan of Tennessee, Inc. (HNHT), was contracted with the State of Tennessee as a health maintenance organization (HMO) to provide medical

services under the newly established TennCare Program. Effective December 31, 1996, HNHT merged with and into Heritage National Healthplan, Inc. (HNHI). HNHI changed its name to John Deere Health Plan, Inc., effective June 30, 1999. JDHP is a wholly owned subsidiary of John Deere Health Care, Inc., which in turn is a wholly owned subsidiary of Deere & Company. The Enrollment in the TennCare Program for the plan was approximately 26,100 members at December 31, 1998, and approximately 34,015 members at December 31, 1999.

As an HMO, JDHP files quarterly and annual statements with the Department of Commerce and Insurance. The department uses the information filed in these reports to determine if the health maintenance organization meets the minimum requirements for statutory reserves. The statements are filed on a statutory basis of accounting, which differs from generally accepted accounting principles in that "admitted" assets must be easily converted to cash to pay for outstanding claims. "Non-admitted" assets such as furniture, equipment, and prepaid expenses are not included in the determination of plan assets and are reduced from equity. At December 31, 1999, the plan had a restricted deposit of $1,800,000 to satisfy requirements of the Department of Commerce and Insurance.

The annual statement for the year ended December 31, 1998, reported $134,875,419 in plan assets, $72,663,074 in liabilities, and $62,212,345 net worth. JDHP TennCare Operations reported total revenues of $36,893,201 and total expenses of $31,424,636, resulting in a net income of $5,468,565 for the year ended December 31, 1998. Revenue consisted of $36,269,328 in premiums received from TennCare and $623,873 in miscellaneous revenue. Expenses consisted of $26,092,235 in medical expenses and $5,332,401 in administrative expenses.

The annual statement for the year ended December 31, 1999, reported $134,003,973 in plan assets, $62,967,555 in liabilities, and $71,036,418 net worth. JDHP TennCare Operations reported total revenues of $52,325,705, total expenses of $52,277,187, and provision for income taxes of $16,954, resulting in a net income of $31,564 for the year ended December 31, 1999. Revenue consisted of $52,325,705 in premiums received from TennCare. Expenses consisted of $44,428,331 in medical expenses and $7,848,856 in administrative expenses.

SCOPE OF THE EXAMINATION

Our examination covers certain financial-related requirements of the contract between the state and JDHP for the period January 1, 1998, through December 31, 1999. The requirements covered are referred to under management's assertions specified later in the Independent Accountants' report. Our examination does not cover those portions of the contract concerning quality of care, clinical, and medical requirements.

PRIOR EXAMINATION FINDINGS

The previous review of JDHP for the period January 1, 1996, through December 31, 1997, included two findings: deficiencies in the claims processing system and deficiencies in provider contract

language. JDHP did not fulfill contract reporting requirements and processing efficiency requirements for TennCare operations. The claims processing system did not record all procedure codes and diagnosis codes for certain claims. Several claims were improperly denied or the amount paid was incorrect. Some of the language that is required for the provider contracts was missing or inadequate. The prior findings will be repeated in the current report (see the Findings and Recommendations section of this report).

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Independent Accountant's Report

May 11, 2000

The Honorable Don Sundquist, Governor
and
Members of the General Assembly
State Capitol
Nashville, Tennessee 37243
and
Mr. Mark Reynolds, Director
Bureau of TennCare
729 Church Street, Fifth Floor
Nashville, Tennessee 37247

Ladies and Gentlemen:

We have examined management's assertions, included in its representation letter dated May 11, 2000, that John Deere Health Plan, Inc., complied with the following requirements during the year ended December 31, 1998, and the year ended December 31, 1999:

- Assets and liabilities are properly classified as "admitted" or "non-admitted" on the annual National Association of Insurance Commissioners (NAIC) report which is completed on a "statutory basis of accounting" and filed with the state.

- The organization is in compliance with the minimum equity requirements as specified in the contract with the state.

- The organization has complied with its contractual duty to provide certain member services to its enrollees such as membership cards, provider directories, assignment of a primary care provider, and information on filing grievances.

As discussed in management's representation letter, management is responsible for ensuring compliance with those requirements. Our responsibility is to express an opinion on management's assertions about the organization's compliance based on our examination.

Our examination was made in accordance with standards established by the American Institute of Certified Public Accountants and, accordingly, included examining, on a test basis, evidence about JDHP's compliance with those requirements and performing such other procedures as we considered necessary under the circumstances. We believe that our examination provides a reasonable basis for our opinion. Our examination does not provide a legal determination on JDHP's compliance with specified requirements.

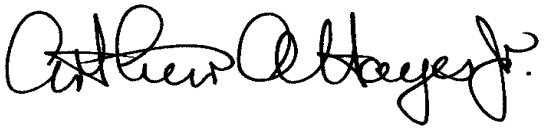
Our examination disclosed the following material noncompliance applicable to JDHP:

- The organization did not comply with contractual claims processing requirements.
- The organization did not comply with contractual reporting requirements.
- The organization did not comply with contractual requirements concerning its agreements with subcontractors and providers.

In our opinion, except for the material noncompliance described above, management's assertions that JDHP complied with the aforementioned requirements for the year ended December 31, 1998, and the year ended December 31, 1999, are fairly stated, in all material respects.

This report is intended solely for the use of the Tennessee General Assembly and the Tennessee Department of Health. However, this report is a matter of public record and its distribution is not limited.

Sincerely,



Arthur A. Hayes, Jr., CPA, Director
Division of State Audit

AAH/pn

FINDINGS AND RECOMMENDATIONS

1. Deficiencies in claims processing

Finding

John Deere Health Plan, Inc. (JDHP), did not fulfill contractual claims processing requirements. A review of 60 claims for services provided from January 1, 1998, through December 31, 1999, revealed the following:

a. JDHP's denial of six claims was improper:

- Two claims were denied because the provider had not obtained a referral or pre-certification. JDHP's authorization system confirmed a referral had been granted for one of the claims and a precertification had been granted for the other claim. JDHP later reprocessed and paid both claims.

- One claim did not contain any denial reasons, but the payment was stopped because JDHP needed further explanation of the HCPCS code. Therefore, this claim was denied incorrectly without explanation but was later resubmitted and paid.

- Two emergency room claims were denied because the primary diagnosis was not considered an emergency. However, per JDHP's internal policies, they are to pay lab and radiology charges for all emergency room claims regardless of the diagnosis. Both claims were later reprocessed, and the lab and radiology charges were paid.

- One claim was denied because the enrollee was not currently eligible at the date of service. The TennCare system shows the enrollee eligible at the date of service.

b. JDHP incorrectly paid eight claims:

- One claim did not pay in agreement with the negotiated rate. The claim was later reprocessed and the additional amount paid.

- One claim incorrectly denied two procedures as duplicates when the services were provided on different days. The remainder of the claim was paid but later recouped by JDHP because Medicare was primary.

- One claim incorrectly applied a copayment to one line of the claim when the service was preventative. Copayments are not to be applied to preventative services. This claim was later reprocessed and corrected.

- One claim had a copayment applied for dates of service when the enrollee did not have any liability per the TennCare system.

- One claim erroneously applied a 50% copayment to one line of a pharmaceutical claim. This was later reprocessed and corrected.

- One claim resulted in a total of $307.72 deductible taken on one enrollee. The maximum allowable deductible per enrollee is $250.00.

- One claim did not apply the applicable copayment to all procedures.

- One claim applied a 6% copayment when the TennCare system reports the enrollee is only responsible for a 4% copayment.

c. For seven claims, not enough information was provided to determine if the claim was properly adjudicated. These claims were processed by JDHP's pharmacy subcontractor.

d. Nineteen incorrect Explanations of Benefits (EOBs) were provided to the TennCare enrollees:

- Seventeen of the EOBs showed the enrollee owed the entire amount of the claim when the entire claim was denied or the total dollar amount denied when only a portion of the claim was denied. In each of these instances, the enrollee did not have any liability.

- One EOB shows the enrollee has a copayment liability when the enrollee was incorrectly charged a copayment on a preventative service.

- One EOB shows the amount billed on the claim was zero, yet the claim reflects the $230.00 charge.

e. JDHP paid 95% of the clean claims tested within the 30-day requirement but failed to pay the remaining 5%, or 100% of all clean claims, within ten calendar days. Clean claims are those that can be processed without requiring additional information from the service provider. Of the 60 claims tested, all 60 were clean claims with the following time lags:

- 58 claims within 30 days (96.6%)

- 1 claim within 40 days (1.7%)

- 1 claim within 60 days (1.7%)

Recommendation

JDHP should adhere to contract reporting and processing efficiency requirements for claims processing. Claims should not be denied for not obtaining a referral or precertification when the provider has obtained an authorization. A denial reason should always be communicated to the provider when a claim is denied. Emergency room claims should be processed according to JDHP's internal policies. JDHP should not deny claims for failed eligibility when the dates of service are within the enrollee's effective dates of coverage. Claims should be paid according to the negotiated rate. Procedures should not be denied for duplicate when they were provided on different dates of service. Copayments should not be applied to preventative services. Deductibles and copayments should be applied to enrollees per the percentages assigned by TennCare. EOBs should not reflect enrollee liability when none is applicable. All clean claims should be processed within 40 days.

Management's Comment

- Refer to c. John Deere Health provided a copy of the pharmacy claims history and a copy of the screen prints showing how the claim was paid. However, due to the rapid repricing of drugs, we were unable to validate the pricing paid for individual medications historically. Our systems do not capture old pricing schedules, as they may change on a weekly basis.

- Refer to d.1. Upon review of the deficiencies, Customer Support adjusted incorrectly processed claims and processing procedures were reviewed with appropriate staff. In addition, a team has been formed to review denial reason codes and how the system is programmed to identify codes which are incorrectly driving dollars into the "patient owes to provider of service" field on the Explanation of Benefits.

- Refer to e. Pended claims reports are utilized by supervisory staff to resolve aged claims. In addition, monthly turnaround reports are generated to determine turnaround performance.

2. Deficiencies in encounter data reporting

Finding

JDHP inadequately reported encounter data required by the TennCare contract. Encounter data, a record of medical services provided to enrollees, are necessary for evaluation of quality of care and access to TennCare services. The following deficiencies, on a review of 60 claims, were discovered for encounter data reporting:

- For five claims, all listed diagnosis codes were not reported as encounter data. The list of required encounter data elements includes up to five diagnosis codes.

- For one claim, the claims processing system did not capture the diagnosis codes, procedure codes, or the billed amount.

- One claim did not capture the information on the second procedure because the procedure had been previously paid. For encounter data purposes, this procedure should have been captured and then denied for having been previously paid.

Recommendation

JDHP should correctly report encounter data as specified in the TennCare contract.

Management's Comment

John Deere Health will be converting to a new claims processing system with an expected implementation date of April 2002. The system will capture the diagnosis codes and the procedure codes currently not captured but required for encounter data reporting.

3. Provider contract language deficiencies

Finding

JDHP did not comply with the TennCare contract requirements for provider contracts. Language describing the following requirements in Section 2-18 of the TennCare contract was missing or inadequate in a contract between JDHP and a medical provider:

- Specify that both parties recognize that in the event of termination of this Agreement between the CONTRACTOR and TENNCARE for any of the reasons described in Section 4-2 of this Agreement, the provider agreement shall terminate immediately and provider shall immediately make available, to TENNCARE, or its designated representative, in a usable form, any or all records, whether medical or financial, related to the provider's activities undertaken pursuant to the MCO/provider agreement. The provision of such records shall be at no expense to TENNCARE.

- As of October 31, 1995 contain a provision requiring resolution of disputes by arbitration, approved by TENNCARE, which shall include the following or similar language: Specify that if any dispute arises between the parties involving a contention by one party that the other has failed to perform its obligations and responsibilities under the agreement, then the party making such contention shall promptly give written notice to the other. Such notice shall set forth in detail the basis for the party's contention, and shall be sent by Certified Mail – Return Receipt Requested. The other party shall within thirty (30) calendar days after receipt of the notice provide a written response seeking to satisfy the party that gave notice

regarding the matter as to which notice was given. Following such response, or the failure of the second party to respond to the complaint of the first party within thirty (30) calendar days, if the party that gave notice of dissatisfaction remains dissatisfied, then that party shall so notify the other party and the matter shall be promptly submitted to inexpensive and binding arbitration in accordance with the Tennessee Uniform Arbitration Act at Tennessee Code Annotated Section 29-5-301 et seq., with the costs of establishing any arbitration procedure being borne by the CONTRACTOR. TENNCARE shall have no involvement in said arbitration except to (1) enforce this subsection (2) approve the arbitration procedure proposed by the CONTRACTOR and (3) to voluntarily intervene if TENNCARE deems intervention to be in the best interest of the system provided however that TENNCARE shall not be bound by said arbitration. If at any time TENNCARE decides that a particular dispute should be in a court of competent jurisdiction, TENNCARE shall notify the parties to the dispute of its decision to refer the dispute to a court of competent jurisdiction and said arbitration process shall cease and the dispute shall be heard in said court. The only exception to the arbitration process shall be resolution of the cost for emergency medical services Section 2-3.m.2. If a dispute between the parties involving a claim submitted by a provider to the CONTRACTOR is not resolved prior to entry of a final decision by the arbitrator(s), then the prevailing party at the arbitration shall be entitled to award of reasonable attorney's fees and expenses from the non-prevailing party. Reasonable attorney's fees means the number of hours reasonably expended on the dispute multiplied by a reasonable hourly rate, and shall not exceed ten percent (10%) of the total monetary amount in dispute or $500.00 whichever amount is greater.

The arbitration procedure proposed by the CONTRACTOR shall be submitted to the Tennessee Department of Commerce and Insurance, TennCare Division for review and approval within thirty (30) calendar days of execution of this Agreement. If the CONTRACTOR has an existing alternative arbitration procedure, the CONTRACTOR may submit the existing arbitration procedure to the Tennessee department of Commerce and Insurance, TennCare Division for review and approval. The Tennessee Department of Commerce and Insurance, TennCare Division shall approve or deny the proposed arbitration procedure within thirty (30) calendar days after the receipt of the proposal from the CONTRACTOR. Any subsequent modification to the arbitration procedure by the CONTRACTOR must also be reviewed and approved by the Tennessee Department of Commerce and Insurance, TennCare Division. Said modification shall be sent by Certified Mail-Return Receipt Requested to the Tennessee Department of Commerce and Insurance, TennCare Division, and the TennCare Division shall approve or deny the proposed modification within thirty (30) calendar days after the receipt of said modification from the CONTRACTOR.

This provision shall apply to any and all disputes that arise between the CONTRACTOR and a provider after October 31, 1995. Any disputes that arise between the beginning effective date of this Agreement and October 31, 1995 shall be governed by the arbitration provisions described in the preceding Agreement between TENNCARE.

- At the next renewal, but no later than December 31, 1998, require that if any requirement in the provider agreement is determined by TENNCARE to conflict with the Agreement between TENNCARE and the MCO, such requirement shall be null and void and all other provisions shall remain in full force and effect.

Recommendation

JDHP should comply with the TennCare Bureau's requirements regarding provider agreements. The provider agreements should contain all items specified in section 2-18 of the TennCare contract.

Management's Comment

John Deere Health agrees with the findings regarding deficiencies in a specific subcontract. We are working to incorporate all required language in new contracting agreements with that specific subcontractor.